SPSO decision report

Case: **201800496, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C, a support and advocacy worker, complained on behalf of her client (Ms A) about the care and treatment Ms A received at Queen Elizabeth University Hospital following an operation. Ms A also considered that she had not received a transparent account of events of her post-operative care.

We took independent advice from a nurse. We found that Ms A had issues with urine retention after surgery. Ms A reported not feeling well and this was responded to by nursing staff; however, no attempt was made to catheterise (a process that involves inserting a tube to the patient's urethra to allow urine to drain freely from the bladder for collection) Ms A, prompt her to self-catheterise or to take a bladder scan. We also noted there were inadequate records of Ms A's fluid balance.

Ms A also had issues with the surgical stockings she was required to wear after her operation, as she found these to be too tight. We noted that according to the Scottish Intercollegiate Guidelines Network (SIGN) guideline 122 a lack of mobility after surgery put a patient at risk of venous thromboembolism (a blood clot that starts in a vein) and devices such as surgical stockings should be worn unless there are specific reasons why these should not be used. We noted that there was no record of an assessment being carried out and we considered this should have been documented. However, as there was no evidence in the notes to raise concerns about the fit of the stockings, it was reasonable that these were worn.

In relation to the board's response to Ms A's complaint, we found that the board did not provide a full, objective and proportionate response.

We upheld both of Ms C's complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms A for failing to perform a bladder scan and/or prompt Ms A to self-catheterise, failing to keep adequate records and for failing to provide Ms A with a full and objective response to her complaint. The apology should meet the standards set out in theSPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Nurses should have clear guidelines to ensure a consistent approach to the indicators patients should achieve during an assessment period or a trial of voiding post catheter removal.
- Assessment of the suitability of surgical socks recorded prior to application and regular review of these should be documented as part of ongoing care planning.

In relation to complaints handling, we recommended:

- The board should follow their complaints handling procedure and issue appropriate responses.